Linn County SIM C3:

Addressing the Social Determinants of Health

Cindy Fiester & Hayley Hegland

"Coming together is a beginning, staying together is progress, and working together is success."

– Henry Ford

Linn County, IA

Why focus on *Community* Care Coordination?

- Providers indicated they didn't know what happened to their clients once they left their organization
  - No "closed loop"
- Duplication of work or missed opportunities for collaboration
  - Need to enhance the work already being done in Linn County
- Clients indicated frustration with finding resources and retelling their story

Why is Collaboration Important?

- Can help provide ***client-centric care***
- Decreases referral "dead ends"
- Helps organizations identify and address broken workflows or resource gaps
- Reduces SDH barriers more effectively

When we work together we can better support clients' needs and their health

Solution: We needed to find a way to help connect and *coordinate* our care coordinators

Building the Connective Tissue

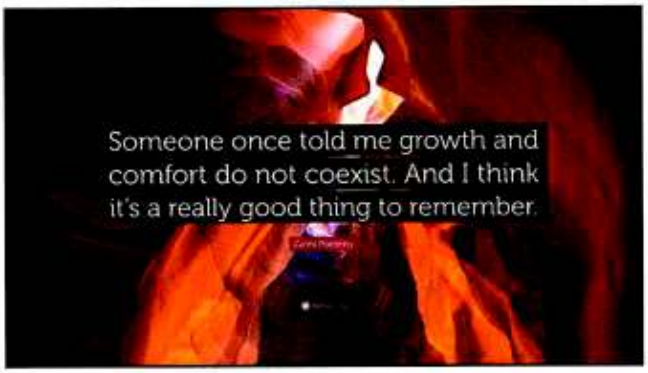
The Connective Tissue

- Adoption and implementation of a collaborative tool: ***TAVConnect***
- Adopted <u>one</u> social needs screening tool and <u>one</u> release of information
  - Utilized by all participating partner agencies
  - *"No wrong door"*
- Increased communication, transparency & <u>opportunities for collaboration</u>

My Care Community

- ***My Care Community*** is an innovative new collaboration designed to improve community health and quality of life for area residents
- By connecting community providers to a shared information and referral network we make it easier for families to access the care they need to stay safe and healthy

My Care Community



As of 3/1/19...

- My Care Community partners have collected and aggregated almost **14,000 social needs assessment surveys**
- Entered nearly **3,000 residents** into the referral population of the TAVConnect system
- **Enhanced relationships and trust** among partner organizations
- Developed a governing structure and **sustainability plan** that will carry this work well beyond the SIM C3 grant
- This innovative, collaborative approach to improving community health received **national recognition** through National Association of City and County Health (*NACCHO*)

Thank You!

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TO: The Governor's Roundtable- Healthy Communities Workgroup

FROM: Marion County Public Health Department

DATE: March 15, 2019

RE: Systemic Recommendations

Thank you for the invitation to provide input into systemic infrastructure discussion. We have many suggestions, which I hope will be considered. Please do not hesitate to request clarification and additional discussion.

Iowa needs a public health system which offers:

- A cohesive system that is able to cross jurisdictional boundaries, yet provides local Boards of Health and agencies the option to competently provide direct service to their constituents
- A cohesive system that works across systemic and programmatic boundaries , including public health, primary care, prevention, home health, mental health, substance abuse
- A system that understands that mental health is a *health* issue, and an important component of many physical health issues.
- A system that understands the social determinants of health contributions to poor health outcomes
- A PH/MH system that works in concert with the health care providers, ACOs, and MCOs
- A system which leverages the payment structures of each system in a way that provides system sustainment. These actions will help leverage those resources:
    - request de-linking of Medicare and Medicaid
    - Strengthen the PH services options under the PH NPI
    - Health Systems (ACOs, MCOs and hospitals) will create sustainability through sharing financial benefit with active partners for better patient outcomes
    - Grant programs will systemically decrease administration and increase service delivery due to economy of scale
    - Those closest to the people served will work inside their area of expertise; managers will manage, and nurses will do community nursing
    - ECI dollars should be planned and collaboration with child health program to eliminate duplication and create efficiencies.
    - Evaluate which DHS grant dollars should be planned/coordinated within this structure
    - Assure IME involvement, so while managing grants, the system is not "grant dependent" or a siloed "grant mindset"
    - Assure that local tax dollars support services inside the local jurisdiction, so that the system does not fall to the same vulnerabilities of the mental health system
    - Require state systems to review contractual requirements, and do not add unnecessary requirements to the already cumbersome federal requirements.
    - Require streamlining of state programs and staff at the state level.

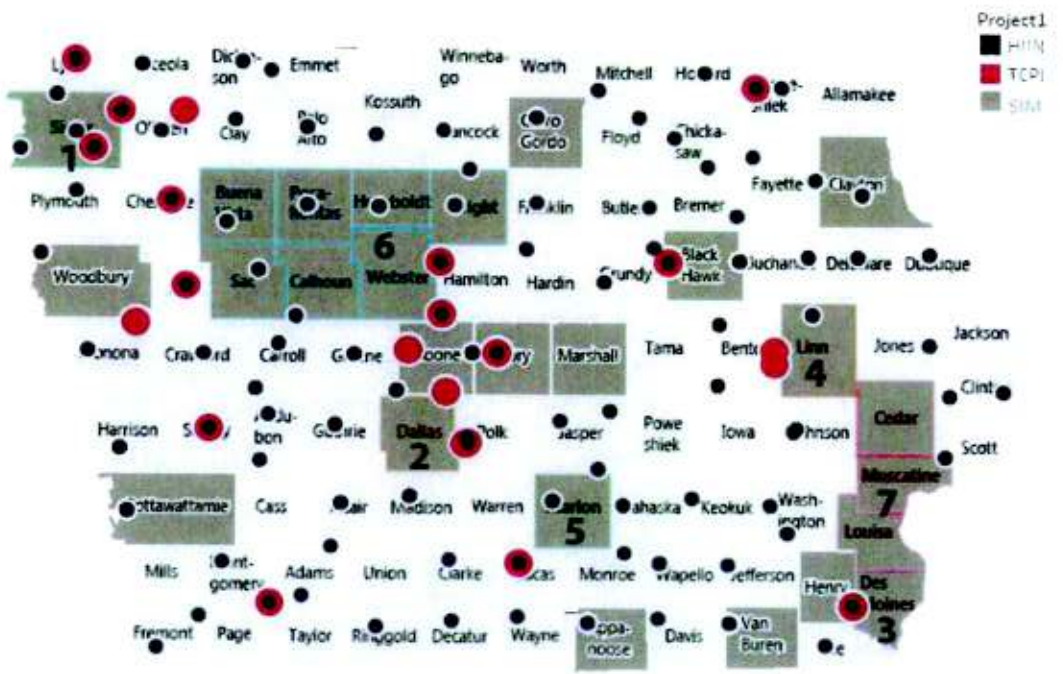
Certainly, these actions would meet with opposition at all levels, however, we believe that these steps would be a great start to a comprehensive system of care that leverages the strengths of all systems. Please do not hesitate to contact me for further information. I can be reached at kdorn@marionph.org, 641-828-2238x231.

The Iowa Healthcare Collaborative

Leading Sustainable Healthcare Transformation

Who We Are

The Iowa Healthcare Collaborative (IHC) is a provider-led, patient focused nonprofit organization dedicated to sustainable healthcare transformation. We are nationally recognized for achieving demonstrable and sustainable improvements across healthcare settings and disciplines. As a trusted advisor, honest broker, and sense maker, we are the only organization in Iowa that convenes providers, payers, patients, communities, and government to build a unified approach to healthcare delivery and finance – all for better, healthier outcomes.



Raising the Standard of Care

Impacted more than **12 million** patients and families

Achieved more than **$448,138,680** in total program cost savings

Aligned and equipped **152 hospitals**, **8,000 clinicians**, and **22 communities** across **18 states**

Reduced unnecessary hospitalizations by **2,000**

Successfully transitioned more than **2,700** providers to a value-based payment model

Reduced inpatient falls by **15.89%**

Reduced inpatient adverse drug event rate by **26.88%**

Hospitals: 152
80% Critical access hospitals (CAH)
20% urban

Clinicians: 8,000
901 Total practices
51% Primary care practices
49% Specialty care practices

Communities: 22
68 Health systems
16 Public health agencies
8,344 Community partners and stakeholders

IHC

Marion County Public Health Department

IOWA SIM

MARION COUNTY

- Located 40 minutes SE of Des Moines.
- Pop. 33,000+
- Knoxville
- Pella
- Lake Red Rock
- Manufacturing
- Agriculture
- Tourism

IOWA SIM

Clinical & Community Healthcare Integration

- Community Based Care Coordination Pilot
  - 20+ non-ACO patients
    - A1C > 8 for 6 months or longer
    - CBCC – met pt and family where they wanted to meet . . . Home, for coffee, office, etc.
    - Assessed SDH impacting health outcomes
    - Referrals made to non-healthcare services
    - Closed-loop communication to primary care
    - 63.6% had a reduction of A1C after 3 months of interaction with CBCC.

IOWA SIM

Clinical & Community Healthcare Integration

- Data is provided through partnership/EHR Access.
  - 50% actively engaged
    - **60% decrease initial A1C**
  - 50% Disengaged
    - **80% increase from initial A1C**
- Subcohort – 0 ED Readmissions
- "It's not about connecting the resources to the clients. It's about connecting the client to the resources and empowering them to utilize them. Our biggest successes are because this has taken place" – Venessa Stalter

DATA Sharing

- Agreements with KHC and PRHC
- EHR limited access to Cerner/KHC
- TAV DATA
  - Identify barriers
  - Successful/unsuccessful

PARTNERS

- Knoxville Hospital & Clinics
- Pella Regional Health Center
- Knoxville Community School District
- Pine Rest Mental Health Services
- Integrative Health Solutions
- CROSS Region
- City of Knoxville
- First Responders
- HIRTA
- Food Pantries

Collaborations

- **Marion County Coalition for Suicide Prevention**
- **Healthy Hometown Knoxville**
- **THRIVE Knoxville**
- **Marion County Change Coalition**
- **Food Coalition**
- Marion County Providers
- Community Care Coalition
- **ESL Classes/DMACC**

Measuring Successes

- DATA
- Outcomes: Health and Client Successes
- Partnerships: Organizational and Personal
- Project growth: Client and CBCC empowerment
- Sustainability

- . . . AWARDS!

Healthy Hometown Knoxville

2019 Healthiest State Award Winner

Barriers . . .can be overcome.

- EHR Access
- Identifying where we're going to align
- Geography
  - Competing Health Systems
  - Competing services
- Communication
  - Are we speaking the same language? YES! Clarify and redefine terminology.
- CBCC
  - Disciplines: Clinical vs. Non-Clinical
  - Staff changes

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Marion County Senior Nutrition

- Identified Problems:
  - Declining participation at senior centers
  - Budget has increased to 450k/year
    - Most comes from local county tax dollars
  - Kitchen infrastructure is failing
  - Insurance requirements- volunteer background checks
  - Fiscally not responsible
    - "voluntary confidential contribution"
    - Cash through many hands of unknown people
  - We don't know our clients
  - Need improved program coordination

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Knoxville participation

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Data

- In the last 6 months:
- Congregate
  - 47% ate fewer than 5 days per month (Knoxville)
  - 40% ate 1 day/month (Pella)
  - 69% ate 1-5 days/month (Pella)
  - 5% ate 1 day/month (Pleasantville)
  - 31% ate every day (Pleasantville)

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Data

Home Delivered19-23 days/month (every day)

61% Knoxville
52% Pella
57% Pleasantville
49% Melcher-Dallas
63% Bussey

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Redesign Goals

- Provide nutrition/food security for seniors who are food insecure
- Target assisting the most at risk seniors
- Flexibility to assist others as an exception to policy methodology
- Impact hospital 30 day re-admissions
- Impact use of emergency room for non-emergent purposes
- Develop a SYSTEM of care for our older population, persons with chronic disease (Alzheimer's, diabetes, heart disease, mental illness)
- Meet program objectives: food security & comprehensive care for those most at risk

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Expense Budgets 2016-(projected) 2020

KCWA SIM

Overhead costs eliminated

KCWA SIM

Financial Structure Improvements

- Eliminates significant overhead costs
- Stabilizes the budget and the per meal cost, because most of the cost is based on per meal fees and delivery
  - When number of meals goes up/down, the budget will reflect it
- Creates separation between Centers and Program
  - Eliminates confusion regarding donations-is it for Senior Center or Program?
- System creates financial controls not currently in place
  - Elimination of volunteers handling cash
  - Billing vs. gathering money daily

KCWA SIM

Changes For Participants

- Food security and comprehensive care linkage
- Enrollment process will include intake assessment
  - Formal and informal support system
  - Health (Not a nursing assessment – health overview)
  - social determinants of health
  - Financial
    - Sliding fee determination
    - Eligibility for other needed services
- Link to other community level supports
- Ongoing Care Coordination, documentation of need & assistance

Prep & Delivery Changes

- Community based congregate
  - Closing of the Knoxville kitchen
    - 4/19
  - Agreements with selected licensed food establishments
    - Pella 2/19, Knoxville 4/19
  - If Senior Boards wish to make their locations available to seniors, individuals may have their meal delivered to that location through home delivery process

Home Delivery Changes

- Contract for meal preparation and packaging
  - Pella - as part of supported employment program
  - Remainder of county- TBD may expand supported employment option, or may contract prep and packaging in Knoxville
- Sunset volunteer system and contract for delivery in Knoxville & Pella as part of supported employment program
- Delivery time may vary some from current schedule

A Better Approach

- Continues to address food security for seniors who meet eligibility requirements
- Maintains both congregate and home delivery options
  - Maintains ability to eat at current center, pending senior boards allowing meal drop
- Creates community congregate options for participants (ie: The Well, potentially restaurant option)
- Supports participant needs more comprehensively

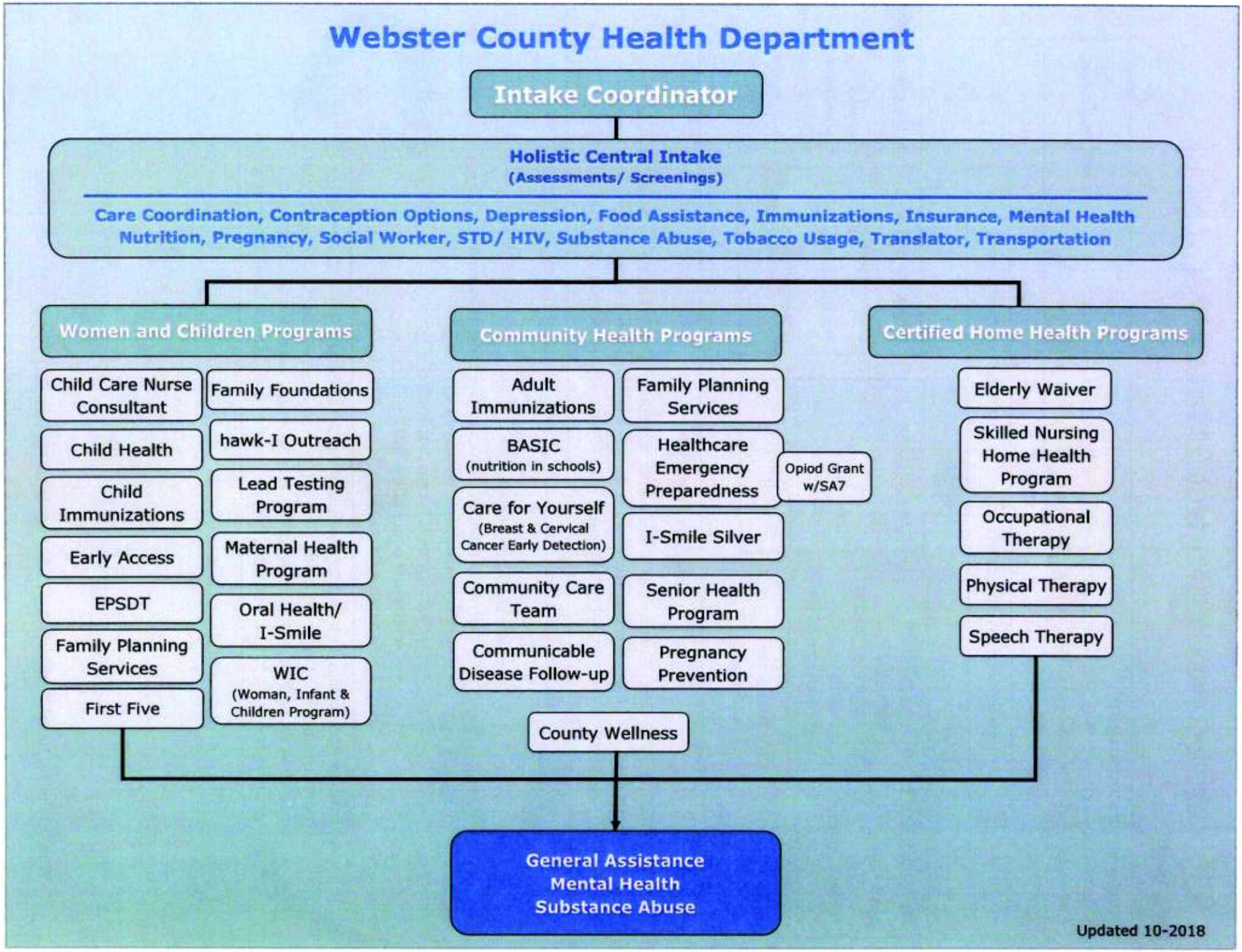
A Better Approach

- Supports systems already in place
  - creates jobs for supported employment
  - Supports kitchens already in place
  - Helps hospitals with 30 day readmission rates/ED use
  - Community Emergency Preparation efforts for vulnerable populations
- More targeted use of tax dollars for service
- Budget is based on services provided, rather than overhead cost
- Eliminates volunteer background check issue
- Creates a **System of Care**

Public Health Systemic Barriers

- Too many competing legal entities
  - Boards of Health
  - Boards of Supervisors
  - Mental Health Boards
  - ECI Boards
  - Community Boards/groups
    - Each has cost of administrative infrastructure
    - Difficulty to find collaborative organizational alignment
    - Competition for same or duplicative dollars among organizations/boards

Webster County Health Department



Webster County Health Department Care Coordination Model

Public Health
Prevent. Promote. Protect.

Referrals into WCHD 1,051
Referral sources: jail, clergy, PCP, city, county, mental health, fire dept., police, schools, families, self, ambulance services, Community para-medicine Program, Emergency Room Planning Meeting, etc.

Intake/Initial assessment by local public health staff to identify need

Economic/stability
677
*Food * housing
* rent *water
* electricity

Health/Health Care - 400
*insurance *dental
*mental health
* behavioral health
*primary care
*substance
*pharmacy

Transportation
415
*taxi *bus
*reliable car
*MCO
*friends/family

Education-400
*highest level
*health literacy
*interpretation

Social/environment
494
*network
*community
*living environment
*social supports

PH Care Coordinator

PRIORITIZE/ RE-PRIORITIZE: What is most critical – what takes priority? Who else do we need to involve? Who else is involved? What other care coordinators would be involved with this person. Who and what do we need to address the most critical component? Who at PH is taking responsibility for care coordination?

- Funding
- Who should be providing care coordination
- What interventions/activities can we assist or coordinate
- Who is primary care coordinator with client
- Follow up with PCP, care coordinators
- Referral out of our office - 819
- Referrals to PCP - 396

Insurance companies, MCO's, prior authorizations, Skilled nursing facilities, VA system, Home Health, DHS, clergy, city funds, city staff, primary care physicians/care coordinators, county funds, housing, Medicaid, school counselors, probation officers, community partners, mental health coordinators, hospital coordinators, General Relief, other resources